

**CHAPTER 792  
FEDERAL EMPLOYEES'  
HEALTH AND COUNSELING PROGRAMS**

**SUBCHAPTER 2  
DRUG-FREE WORKPLACE PROGRAM**

**APPENDIX D  
DOCUMENTATION IN SUPPORT OF A DRUG-RELATED INCIDENT**

Date\_\_\_\_\_

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

UIC: \_\_\_\_\_ Organization: \_\_\_\_\_

Date of Incident:\_\_\_\_\_ Time of Incident:\_\_\_\_\_

Description of the incident leading to the request: (Be specific: e.g., for reasonable suspicion, arrest or conviction of an on or off-duty drug-related offense; direct observation of an employee using illegal drugs; direct observation of an employee tampering with his/her urine specimen; temperature of urine sample outside the normal range, etc.)

Individuals witnessing the incident: (Be specific: use name, title, organization, relationship to person being tested, e.g., co-worker, police officer, spouse, etc., of individual providing information on a drug-related incident.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other pertinent facts or attachments (list):

Documented by: \_\_\_\_\_

(Name - print)

(Title - print)

(Signature and date)

I have reviewed the above details and facts supporting an incident of suspected illegal drug use relevant to the requested test and concur/do not concur.

\_\_\_\_\_  
(Signature, Approving Official) (Date)

*Send this form to Human Resources Office, Norfolk, ATTN: DPC, within 10 days of incident.*

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INTENTIONALLY LEFT BLANK